HYGIENE CHECKLIST

NAME:_____

1. How frequently have you been brushing your teeth? _____

2. How frequently have you been flossing your teeth? _____

YES/NO

3. Do your gums bleed? ____/____

4. Are your gums sore or swollen? ____/____

5. Have your gums receded? (Do your teeth look longer?) ____/____

6. Are your teeth loose? ____/____

7. Do you drink liquids excessively? ____/____

8. Do you have a persistent sore throat or ear pain? ____/____

9. Do you have chronic horseness? ____/____

10. Do you have a lump or thickening in the cheek? ____/____

11. Do you regularely have excessive daytime sleepiness? ____/____

12. Have you been diagnosed with sleep apnea? ____/____

13. Do you have a heart condition? ____/____

14. Do you have a family history diabetes? ____/____

15. Do you have high cholesterol? ____/____

16. Do you snore or have been told in the past that you snore? ____/____

17. Do you have a sore or a lesion on the lips or mouth that has persisted for 2 weeks or more? ____/____

18. Do you have difficulty chewing, swallowing, moving the jaw or tongue? ____/____

19. Do you have unexplained numbness or pain in the face/neck/mouth? ____/____

20. Is there a history of heart disease in your immediate family? ____/____

21. Do you have any other health conditions? ____/____
If yes, please explain: _____